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Boston University Medical Center

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Number 7
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The
Medical
Cost/Quality
Newsletter

The Malpractice dilemma

1. Will PSROs help to resolve the malpractice impasse?

Escalated awareness of the medical malpractice dilemma has focused attention on the possible effects of PSRO organization on physician liability. Whether the PSRO will increase or decrease risks of malpractice litigation for the parties involved rests upon a variety of future developments. The effect of the immunity provision in the law is not clear, but its judicial interpretation will be vital to the malpractice question.

The implementation of PSRO norms,* the types of malpractice legislation developed on a state and federal level, professional and public perception of the role of quality assurance programs all have an important bearing on the outcome of the liability question as it relates to PSROs.

Traditionally, a finding of medical malpractice requires proof that a physician failed to exercise reasonable care and

Malpractice (Continued on pg. 2)

DHEW backs off, declares July 1 as new UR deadline

WASHINGTON, D.C. -- In the face of opposition from organized medicine, the Department of Health, Education, and Welfare has backed away from its earlier determination to stick to the Feb. 1 deadline for implementation of the new *UR regulations.

UR deadline (Continued on pg. 8)

2. Malpractice underwriters hedge their bets on PSRO

While generally conceding that PSROs are a step in the right direction, major medical malpractice underwriters are not now looking to the peer-review organizations to provide much relief in the worsening insurance crisis plaguing doctors and hospitals across the country.

A spokesman for the Hartford Insurance Group, however, told PSRO Update there is a "definite indication" that adherence to certain agreed-upon standards of practice would affect malpractice verdicts favorably. Eugene Cudworth, secretary for professional liability, said, "If (PSRO) standards are set up as guidelines, it would tend to improve the possibility of defending a (malpractice) case."

Underwriters (Continued on pg. 7)

3. Legislators seek answer

As the malpractice insurance crisis deepened this month and threatened an increasing number of doctors with inability to obtain insurance, state medical societies in Massachusetts and New York filed in their respective state legislatures bills designed to reduce the frequency of claims and the size of awards.

A bill calling for a medical injury compensation commission to review malpractice cases was introduced by the Massachusetts Medical Society, and the New York

Legislation (Continued on pg. 7)

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*Norms is used in a generic sense to include norms, standards and criteria.
*UR--Utilization Review

Malpractice
(Continued from pg. 1)

diligence, thus violating an obligation and causing injury to the patient. A physician's performance is measured against the degree of learning and skill ordinarily possessed by his or her peers on either a local or national level, depending upon the case in question.

A NEW FORM EVOLVES

With the creation of the PSRO, a new method of evaluating a physician's performance, which the judiciary may decide to adopt as relevant to a negligence action, is being developed. The outcome of a PSRO determination, and the methodology that that organization utilizes to measure quality may be viewed as relevant factors in proving or negating civil liability. For example, if norms of treatment are admissible in court, deviation from them that is medically unjustified and undocumented could perhaps be utilized by plaintiffs as evidence of malpractice.

Section 1167 of the PSRO law stipulates that physicians who adhere to PSRO norms will be immune from liability, but goes on to state that the immunity will apply only provided "due care" is exercised. The inclusion of the "due care" provision in 1167 places the entire section in question, for it seems merely to reinforce the standard currently in use. A distinction must be drawn between malpractice actions based on negligence in the performance of a given procedure and actions based on a failure to perform or performance of an improper procedure. If the care rendered by the defendant physician was approved by the PSRO as being within the specified norms, this fact should serve as a protection from malpractice actions based on performance of an improper procedure or the failure to act. On the other hand while a given procedure may be medically proper, the physician may be found civilly liable if it is performed in an inappropriate manner, even if the treatment was certified by the PSRO.

The thrust of 1167 is to serve as a defense against malpractice, but the question arises whether deviation from PSRO norms can be used affirmatively to raise a presumption of negligence. The Senate Finance Committee Report on PSROs indicates that failure to follow norms would not raise a presumption of negligence, but courts may have a hard time justifying this position if adherence to norms can be used as a defense.

THE REVIEWERS' POSITION

PSRO review physicians are protected from liability in carrying out their review functions, provided they exercise due care in performing their duties. The PSRO is not liable for faulty determinations, provided the individual or committee conducting the review takes into account all the relevant medical evidence presented. (Reviewers are not obligated to seek information beyond that which is presented to them.) In cases where the review is conducted in a malicious or negligent fashion, both the reviewers and the PSRO organization may be held liable.

The PSRO as a corporation with a legislatively mandated function has a responsibility to exercise due care in the performance of its review function. Failure to properly carry out required functions may expose the PSRO to liability; an example of this can be drawn from the area of sanctions. When a PSRO review committee fails to impose sanctions on a physician whose practice deviates substantially from established norms, the PSRO has not exercised due care and may, if injury results, be held negligent. The PSRO as a corporation is not shielded from liability, but must carefully monitor itself to ensure that its officers, board, employees and agents are properly carrying out their required responsibilities.

VIEW FROM THE COURTROOM

Any conclusion about the effect PSROs will have on malpractice clearly must be speculative. While a physician's failure to conform to PSRO norms or a denial of a claim may in some malpractice cases have evidentiary value, they are events that must be viewed in the context of the PSRO operations. There is a danger that courts and juries will not have an appreciation of what a PSRO is or how it functions; PSROs are not being developed for the courtroom. Admissible evidence of a PSRO denial of payment or of a physician's deviation from norms could easily be construed out of context and possibly have damaging consequences. To utilize PSROs as barometers of malpractice liability may be detrimental to their review activities, hampering review committees' functions and causing them to develop a defensive posture.

It would be unrealistic, however, to think that PSROs will not have some effect on malpractice litigation. It is to be hoped that effect will develop from a realistic understanding of PSRO purpose and function.

Progress Notes from the Northeast

P/S/R/O Update New England & New York

New York

Adirondack Professional Standards Review Organization

GLENS FALLS--Seeking to reach the smaller hospitals, the PSRO here plans to try to use a retrospective review, says Conrad Kaczmarek, executive director.

Meanwhile, the group has submitted the final formal plan to DHEW, Kaczmarek noted.

With additional recruiting, 63 per cent of the 471 eligible physicians have now signed up. Kaczmarek hopes that with some new funding, he will be able to hire staff personnel.

New York County Health Services Review Organization

NEW YORK--More than 4,700 physicians have signed up with the PSRO in Manhattan, according to Eleanore Rothenberg, deputy executive director. The group has just submitted its revised formal plan to HEW.

"We have an enormous job to do," Rothenberg pointed out. "There are 40 hospitals, with 500,000 admissions a year, and 250,000 of these will be under the purview of PSRO."

A response of 45 letters has been reported by the External Affairs Committee, headed by Dr. Jay Reibel. This committee has been organized into subcommittees, and has sent letters to 65 organizations, including specialty health-care organizations and state health officials. The replies indicate a willingness to cooperate with the PSRO.

Meanwhile, the PSRO, in response to a request from the Greater New York Hospital Association, prepared an extensive bibliography on sources of medical and surgical criteria.

Area 9 PSRO of New York State

PURCHASE--The group here has completed a 30-page hospital-review system, prepared with the help of the utilization-review chairman, according to Michael Maffucci, executive director. "A meeting is scheduled with hospital utilization-review people, and we hope the plan meets with their approval," he said.

"Then we hope to have a second meeting with administrators and chiefs of staff to bring them up to date on what we've done," Maffucci noted. "Afterward we'll send them a formal hospital plan, and see what they want to submit as a plan."

Erie Region PSRO, Inc.

BUFFALO--Six committees of the PSRO here are now functioning, with emphasis on the hospital-liaison, criteria and review committees, says Warren Mutz, program director.

"The first function of the review committee will be to review the hospitals' capability to receive delegation for utilization review," he said.

Kings County Health Care Review Organization

BROOKLYN--The PSRO here is establishing an advisory board to work with the board of directors. The advisory board will consist of representatives of the Committee of Interns and Residents, an R.N. from the American Nursing Association's state body and a dentist, according to Sheryl Buchholtz, associate director.

"We receive letters regularly from people asking to be involved," Buchholtz said. "The next time, we'll put a pharmacist and a podiatrist on the board.

"Our board of directors is now composed of 15 physicians and three lay people (two of the three are hospital administrators)."

Nassau Physicians Review Organization

GARDEN CITY--The PSRO here is seeking to discover how many hospitals will perform the review function, and how many would be handled by the PSRO, according to Eugene O'Reilly, project director.

"We have developed a methodology of evaluating the individual hospitals on the utilization-review aspect," he said. "The next step would involve additional personnel, and depends on the total number of people involved."

Professional Standards Review Organization of Rockland

NANUET--The PSRO here is now evaluating the capability of three short-stay hospitals to perform utilization review, according to Jack Cohen, executive director. These are Good Samaritan, Ramapo General and Nyack Hospitals.

"We have their preliminary letters of intent, signifying their intent to seek delegation," he said. Two have submitted formal plans and the third hospital is revising its first plan.

The Bronx Medical Services Foundation, Inc.

BRONX--The PSRO here is engaged in writing criteria for standards for admission certification and continued-stay review, Harry Feder, administrator, reports.

"We have mailed guidelines for delegation to all the hospitals and have given them 30 days to respond," Feder said.

Physician reimbursement: New York PSRO policy varies

The question of reimbursement is being handled in varying ways by New York State PSROs, a survey by PSRO Update shows.

In Brooklyn, the Kings County Health Care Review Organization is reimbursing physician members of the speakers' bureau with a flat rate of $75 a lecture, and is paying $35 an hour to physicians assigned to specific projects.

In the Buffalo area, the Erie Region PSRO is following the general federal guide of $35 an hour, and is only paying this to physicians "doing what would be considered consultants' work."

A roundup of New York ideas on reimbursement follows:

Nassau Physician Review Organization: "Much of the time is being donated," Eugene O'Reilly, project director, said. "We have paid for certain services--such as development of criteria, norms and standards--at the rate of $35 an hour," he said. "It is not a major issue. I do most of the speaking at hospitals, and members of the executive committee do it gratis."

Adirondack Professional Standards Review Organization: "On the question of doing review work in the hospitals, such as review of charts, etc., that would be consultants' work, and that would be at a $40 an hour rate," Conrad Kaczmarek, executive director, says. "Speakers are not reimbursed--this is their organization, and to me it would be repugnant. Our doctors have been traveling as far as 170 miles for no compensation. The only time we would pay is if it's a non-delegated hospital, and the physician would be paid for any time devoted to admissions and continued-stay review."

Kings County Health Care Review Organization: "We've paid a flat rate of $75 to physicians going out to speak to hospitals for us," says Sheryl Buchholtz, associate director, "that is, to a hospital that is not their own. The time runs about three to four hours a night, counting travel, lecturing and answering questions, and we don't consider the $75 high. One physician spent several hours drafting a review plan, and we paid him $35 an hour. For such tasks, we feel the physicians are entitled to reimbursement."

New York County Health Services Review Organization: "The policy has been that during the planning stage, the physicians have been volunteering their time," says Eleanore Rothenberg, deputy executive director. "When physicians do staff type of work, developing UR procedures, specific criteria, etc., then they'll be paid by the hour. We will pay less than $75 for lectures by speakers."

Erie Region PSRO, Inc.: "If it's task-related, or produces a result, it's reimbursable," says Warren Mutz, program director. "If you just review the work of other committees, it's not reimbursable. We're going along with the average Federal guide of $35 an hour. We're not paying for attending executive committee meetings or things like that."

Area 8 PSRO of New York State: "If physicians do a particular job, or work on development of criteria, we pay at the rate of $35 an hour," according to Michael Maffucci, executive director. "We're trying to establish some method where if a physician gets a task, in which the decision is made by the executive committee to map a study, he would then be paid. But a physician wouldn't be paid for just attending meetings or being on a board. Frankly, we've paid the physicians very little. Most of their time has been donated. However, we feel there has to be some balance--and that you have to pay for some of their time."

The Bronx Medical Services Foundation, Inc.: "All of our physicians have volunteered their time," says Harry Feder, administrator. "We haven't paid any development costs for doctors. If we need it, we'll do it--that is, pay for specific services. In our proposal to HEW, we have asked for money for 500 hours at $35 an hour, to cover this reimbursement question."

New England

A summary of the status of the 13 PSROs in New England looks like this: the two that received conditional designation last July (out of 11 in the country) are now in phase II; they are Bay State and Charles River, both located in greater Boston. All the rest are in the planning stage; nine of these sent in their proposals for conditional status by March 1, and of the remaining two, Vermont PSRO expected to file by the first of this month, and Central Massachusetts PSRO in Worcester received an extension of deadline to May 26, the delay resulting from a change of executive directors. The planning PSROs which have submitted their proposals for conditional status are those in: Rhode Island, New Hampshire, Maine, Southern Massachusetts (Middleboro), Western Massachusetts (Springfield), Eastern Connecticut (Willimantic), New Haven, and Fairfield County, Conn.

For the majority of these planning PSROs, the current limbo (between submission of the proposal and expected designation) is filled with "interim tasks" required by OPSR. Some of these tasks involve working on memoranda of understanding with hospitals, developing criteria, devising a data system, exploring the extensions of PSROs to long-term care facilities, and working with hospitals on UR regulations.

OPSR has appointed a new project officer, Daniel Nickelson, to work with the region's two largest PSROs - Bay State and Charles River - and with the Massachusetts State Support Center, the Commonwealth Institute of Medicine. Nickelson, who made site visits in mid-March, will thus be lightening some of the load heretofore carried by Tina Forrester, project officer for the other Region I PSROs.

Following are brief notes from each of the PSROs in Region I, followed by a report on how PSROs here are reimbursing physicians.

Bay State PSRO

BOSTON, Mass. -- Gary M. Janko, who became executive director in early March, says Bay State is getting ready to start field testing a data system in three or four hospitals. Area hospitals are anxious to see the question of a data system settled, he notes, because the Massachusetts *CHAMP has been in operation with a data system for some time that is different from the new PSRO system.

In the realm of politics, a Boston press report identified a split within the 21-member board of directors, resulting in the resignation of the former executive director, and it broached the possibility of the demise of this "model" PSRO. The issues were said to have concerned a potential conflict of interest because of overlapping membership on the (public) PSRO and the (private) Bay State Foundation and because member physicians sit on boards which both provide health services and monitor them.

After this report, a joint meeting of the Foundation and the PSRO heard legal opinion which denied a conflict, and at which PSRO President Robert J. Brennan said "there was unanimous agreement of no conflict of interest." He called it "a tempest in a teapot," and said Bay State PSRO was moving along quite well.

Charles River Health Care Foundation

NEWTON, Mass. -- A memorandum of understanding has nearly been completed between Charles River and the Medicare state agency, and on its completion, the PSRO is expected to begin its review activities, according to Lewis S. Pilcher, M.D., executive director.

Southeastern Massachusetts PSRO (SEMPRO)

MIDDLEBORO, Mass. -- Executive Director Paul Egan reports that over the next three months, before the anticipated contract signing for conditional status, SEMPRO will concentrate on preparing hospitals for review activities and working with its 16 area hospitals on UR regulations.

Central Massachusetts Health Care Foundation, Inc.

WORCESTER, Mass. -- New Executive Director Richard W. Kaplan reports that since he was appointed March 5 he has been working on the application for conditional status, now due May 26. Kaplan had formerly been with the Regional Medical Program.

Western Massachusetts PSRO, Inc.

SPRINGFIELD, Mass. -- Encouraged by OPSR to take advantage of fiscal 1975 funds, Western Massachusetts PSRO completed its proposal for conditional designation by March 1 and expects to be one of the early conditionals in the area, says Executive Director Charles E. Everett.

The 16 medical and surgical speciality committees have completed the first round in drawing up criteria for admission certification and continued-stay review, Everett indicates.

*CHAMP--Commonwealth Hospital Admissions Monitoring Program

Rhode Island PSRO, Inc.

PROVIDENCE, R.I. -- From Executive Director Edward J. Lynch comes word of a trend to increased awareness of PSROs. He says he's spending time, at the request of individuals such as graduate students and administrative residents, explaining PSROs.

Connecticut Medical Institute (CMI)

NEW HAVEN, Conn. -- The number of queries about PSROs from allied health professionals has increased noticeably lately, says Joseph Marin, executive director of the State Support Center. The pressure toward peer review in all health fields has prompted this increased interest in what physicians are doing through PSROs.

Eastern Connecticut PSRO, Inc.

WILLIMANTIC, Conn -- With a vacancy in the top staff post, the personnel committee expects to hire an executive director this month.

Preparations are going forward for the first annual meeting in May, reports Robert Gillcash, M.D., medical director. He also notes that all seven hospitals have review coordinators.

Hartford County PSRO, Inc.

HARTFORD, Conn. -- Program Director Norman Reich reports that his PSRO is waiting for Washington to approve the second phase of interim tasks, action he had hoped for by the end of March. It would clear the way financially to carry out work on the memoranda of understanding with agencies for the Titles V, XVIII and XIX, and for a teaching agreement with hospitals on delegation of review responsibility.

Connecticut Area II PSRO

NEW HAVEN, Conn. -- "A major move," reports John H. Herder, executive director, "has been the appointment of a medical director for Connecticut Area II PSRO. This is important because we are a free-standing PSRO, with no tie-in to a medical foundation." Without the support of a medical-foundation, this PSRO has not had the medical personnel that others could tap easily, Herder says.

PSRO of Fairfield County, Inc.

BRIDGEPORT, Conn. -- Executive Director Gregory Martel reports that the Fairfield PSRO is continuing to work on the pre-conditional tasks agreed to with the federal government.

New Hampshire Foundation for Medical Care

DURHAM, N.H. -- Weekly meetings to work out UR plans have been taking place in New Hampshire with the fiscal intermediaries, hospitals, the Medicare state agency and the PSRO, reports Executive Director Constance Azzi.

Also, a series of symposia on quality assurance has begun.

Vermont PSRO

SHELBOURNE, Vt. -- Once the final draft goes in to Washington, says Executive Director Robert B. Aiken, M.D., the Vermont PSRO will be considered in a pre-conditional phase. He expected completion by the first of this month.

"We're planning to work very closely with the state UR people - the state health and welfare people and the Blues. We're trying to fix it so that as soon as a hospital writes its new UR standards, it will also fulfill PSRO guidelines," he says.

Pine Tree Organization for PSRO, Inc.

AUGUSTA, Me. -- As part of a national experiment, the Pine Tree PSRO is one of five in the country which has been designated as a Private Initiative PSRO (PIPSRO) for the purpose of assessing quality assurance concurrently, instead of retrospectively.

Most N.E. PSROs following $35 guide on reimbursement

While it may still become one of the more pressing problems of PSROs across the nation, the question of physician reimbursement has yet to heat up in New England. A PSRO Update check with the PSROs in Region I reveals that most have been following the federal guidelines, that is, paying $35 an hour for consulting and review work, and for committee work which produces criteria, data system policy or the like.

The PSRO that seems to have put in the most time working out a formula for reimbursement is Charles River, which had been prepared to share its conclusions with others, until its board decided to await the outcome of the National PSRO Council meeting this month. Many PSRO people have been anxious to see this question resolved -- and soon.

The highest rate requested in the region is found closest to New York City, in Fairfield County, where reimbursement of $50 an hour was asked for in the conditional application. Currently, reports Gregory Martel, the payment follows federal limits of $35.

In most PSROs a distinction has been made between paying for attending routine board or committee meetings, and working meetings which produce criteria or guidelines.

Underwriters
(Continued from pg. 1)

The Hartford Group would consider setting a lower rate for doctors with favorable PSRO profiles if it can be demonstrated that PSRO standards are effective in reducing the frequence and severity of claims, Cudworth said. He pointed out that the company now imposes a surcharge on doctors who depart from the standards of voluntary peer-review committees.

"If a doctor were to follow all the tenets of good practice, the potential of a case being found against him would be small," the insurance executive added.

An official of the St. Paul Fire & Marine Insurance Co. said he expects little change in the malpractice picture resulting from the establishment of PSROs. Donald Clifford, vice president for general casualty, said if PSROs do, in fact, improve the situation, malpractice rates would go down, but not on an individual basis reflecting a doctor's rating with his local PSRO.

"It would be very difficult to determine that PSROs had been the cause of fewer claims being filed," Clifford said.

NEW DEAL JULY 1

St. Paul Fire & Marine will stop writing the standard "occurrence" type of malpractice insurance on July 1 and will begin writing a new "claims-made" policy, which covers only claims reported in a given year resulting from professional services rendered in that year.

Terming the St. Paul claims-made policy "totally unacceptable to doctors," Everett Spencer, executive secretary of the Massachusetts Medical Society, said the insurance coverage of many physicians in the state who have never had a malpractice claim is running out and "they have no place to go."

The establishment of PSROs alone will not prevent malpractice suits being brought, Everett said, and added that PSROs have "a long way to go" in organization. However, he said, "I would think any kind of real peer review would lessen the likelihood of (a doctor's) being sued."

PSROs are only a part of the solution to the malpractice problem, according to a spokesman for Aetna Casualty. The idea of selective underwriting for doctors with favorable PSRO standings "deserved investigation" if PSROs can be shown to have an effect on the actual losses paid on claims, the spokesman said.

Aetna has eliminated its malpractice business in several states where it has not been able to get rates it considers adequate or where its business volume was small.

Legislation
(Continued from pg. 1)

Medical Society submitted a package of eight bills and an additional proposal calling for a state indemnification board to weigh malpractice claims.

The Massachusetts bill, modeled after workmen's compensation laws, would provide for a voluntary and binding form of mediation and arbitration, with doctor and patient agreeing before the start of treatment whether to submit any future claim to the commission.

LAST WORDS, BEFORE COURTS

Dr. Richard F. Gibbs, chairman of the society's committee on professional liability, said the proposed board would be a legal forum and would have the last word in any malpractice dispute, except for the right of appeal to the superior or supreme courts. Composed of experts in the fields of medicine, law and consumer protection, appointed by the Governor, the commission would delegate the actual hearing of cases to so-called hearing officers sitting on mediating panels.

"The present adversary system is not working for us in the area of malpractice," Gibbs said. "Young men are refusing to come to Massachusetts (to practice medicine)," he added.

The 12-member state indemnification board proposed by the New York Medical Society would represent equally lawyers, laymen, doctors and judges and would be divided into four equivalent hearing panels, one for each of the four judicial districts in the state. The bill also provides that awards would cover health-care expenses, loss of earnings, and any other injury-related expenses incurred from the date of injury, and would set guidelines for compensation for pain and suffering up to a ceiling of twice the amount of the expense payment.

The bills in the NYMS's eight-point legislative package, if adopted, would (1) make admissible as evidence in subsequent jury trials the findings of the now-mandatory mediation panels; (2) reduce the statute of limitations for malpractice to two years, with the time limit not beginning for minors until age four; (3) "eliminate the increasing abuses of the concept of in-

formed consent;" (4) eliminate the specific dollar claim in suit actions (5) require that the courts be notified immediately of the commencement of a malpractice suit; (6) provide that the jury be advised of any other sources of compensation to be received by the claimant in a suit; (7) establish a definition of medical malpractice; and (8) provide that the Medical Board make the final determination in the disciplining of a physician, instead of the Board of Regents.

NEED FOR BASIC CHANGES

Michael Reichgut of the New York Medical Society said the society would "not accept" any legislation that merely provided an insurance vehicle, such as a national reinsurance pool, without providing for the reduction of costs. "We feel there must be changes in the basic system," Reichgut said. "It does no good if they form a pool and costs still go up 200 or 300 per cent."

On the national level, the National Medical Injury Compensation Act (S 215), introduced in the Senate in February by Senators Daniel Inouye (D-Hawaii) and Edward Kennedy (D-Mass.) was still pending before the Senate Health Subcommittee, with hearings before the subcommittee scheduled for April. Field hearings on the bill were scheduled to be held in Worcester, Mass. on April 7.

The bill calls for government compensation on a no-fault basis for injuries received as the result of medical treatment, and requires participating physicians to have their practice reviewed by the local PSRO.

UR deadline

(Contined from pg. 1)

With the AMA suit for an injunction still pending in Chicago, the Department voluntarily postponed implementation of the regulations until July 1.

HOSPITAL DILEMMA CITED

One reason given by the OPSR staff person was that many smaller hospitals across the country lack the in-house capability to perform all the required UR tasks.

The five month delay will give them time to get outside help to meet the regulations, the spokesperson said.

In a related development DHEW Secretary Caspar Weinberger has signed an agreement that as and when PSROs are judged effective, their activities will take precedence over the UR regulations.

Significantly, both these actions followed on the heels of some very serious concerns expressed by physicians at the last National Professional Standards Review Council meeting here.

The feeling surfaced during a discussion of reimbursement issues at the February meeting of the all-physician panel, when Cornelius L. Hopper, M.D., director of the Tuskegee Institute's John A. Andrew Clinic, warned that the future of the PSRO program may hang on how the new UR regulations are implemented in hospitals around the country.

ADVICE FOR WEINBERGER

At his urging, the Council appointed a subcommittee, not only to recommend specific proposals regarding physician reimbursement under PSRO, but also to come up with some "advice" for Secretary Weinberger on how to implement the UR regulations without rocking the PSRO boat.

The Council has, of course, no legal authority to make recommendations regarding the utilization-review regulations, which are administered by SSA's Bureau of Health Insurance, but, as Dr. Hopper commented to PSRO Update, there are strong feelings that "the future of the PSRO program is going to be decided around the Secretary's willingness to bring about true unification of the PSRO and UR regulations."

With regard to the issue of physician reimbursement for PSRO activities, the subcommittee was expected to reaffirm what appeared to be the general feeling of the full Council: namely, that physicians should be reimbursed at the rate of $35 per hour, but only for those activities dealing directly with patient review.

Allan R. Nelson, M.D., president of the Utah Professional Review Organization, said that reimbursement should be based on an hourly rate rather than on a flat fee or case-rate basis. Although review activities are often done in three-or four-minute segments, he said, dealing with time is easier than handling a case-rate system "which could get into problems that could lead to deterioration of service."

Dr. Nelson said reimbursement should be made only for those activities in which an actual review decision is made.